A Guide for Transition Planning
Money Follows the Person Project

Careful transition planning is vital to insuring that individuals who have chosen to move to the community from an institutional setting are successful in their home in the community. Transition planning begins the day that the decision is made to move to the community, and includes intense and ongoing collaboration between the individual and their guardian and family, staff from the developmental center, community ICF-MR, or nursing home, Local Management Entities (LMEs), case manager, residential provider, and others. The case manager or LME care coordinator must take the lead in transition planning and are responsible for following the guidelines listed below for transition planning.

- **Coordinate an initial meeting between the guardian, LME, and the staff of the developmental center, community ICF-MR facility, or nursing home**. This meeting must take place at the institutional setting. The purpose of the meeting is two fold: 1) to meet the individual in their current environment and, 2) to assess the needs and preferences of the person through meeting the person, their guardian and family if desired, discussion with staff, and review of records as appropriate. This will support the identification of an appropriate residential provider and setting for the person. During this meeting information sharing may include but not be limited to:
  - staffing needs (i.e. does the person need staff that have familiarity with autism spectrum disorders, are their specialized medical needs that will require additional staff training, any special characteristics of staff based on the person's preferences, etc.?)
  - level of assistance with activities of daily living needed
  - dietary preferences and guidelines
  - medical challenges
  - current medications
  - assistive technology or adaptive device needs of the person
  - what constitutes a meaningful day for the person (supported employment, vocational training, volunteer work, "retirement" activities, etc.)
  - behavioral challenges, including current behavior support programs and how that plan may need to be adapted to support the person in the community
  - potential residential settings that will best meet the needs of the person (AFL setting, small group home, etc.)
  - what is important to and for the person

  Note: Additional meetings or exchange of information will be necessary to gather additional information to support the transition process.
- **Identify, in collaboration with the person, the guardian and/or other family members, a residential setting and provider agency that meet the staffing and other needs and preferences of the person.**
- **The case manager or care coordinator and staff from the residential provider agency meet with the person, guardian and/or family members and staff at**

the developmental center, community ICF-MR facility, or nursing home. This meeting is similar to the initial meeting with institutional staff and is used for information exchange and residential provider staff orientation to the person, and the person becoming familiar with the staff. Active dialogue continues throughout the transition process between the developmental center/community ICF-MR staff, or nursing home and the residential provider staff regarding needs, services, likes and dislikes, etc.

- **The case manager or LME care coordinator is responsible for working in collaboration with the planning team (LME, residential provider, developmental center, community ICF-MR staff or nursing home, and other individuals who know the person well) to develop a transition plan that includes timelines for the transition process.** The transition plan is submitted to the LME by the case manager **within two weeks** of assuming the individual on their caseload/accepting the referral or is completed by the LME care coordinator within two weeks. The LME care coordinator is responsible for providing a password protected electronic copy of the transition plan inclusive of specific timelines to the MFP specialist/designee at DMA and Sandy Ellsworth/CAP/MR-DD Slot Manager (Best Practice Team, DMH/DD/SAS). The case manager must also provide the developmental center, community ICF-MR, or nursing home a copy of the transition plan. **If a residential provider has not yet been identified within the two week period, a potential date for accomplishing this should be included in the transition plan timeline.**
- **To collaborate with the developmental center, community ICF-MR, or nursing home staff and residential provider to arrange opportunities for residential staff to receive training from the developmental center, community ICF-MR, or nursing home staff in how to effectively support the individual, particularly if the individual has medical or behavioral challenges.** This process may include transition visits by the person to the residential setting accompanied by the institutional staff. It is also appropriate for the residential provider staff to visit the center, community ICF-MR, or nursing home to learn how staff addresses the needs of the person based on the person's preferences and choices as identified in the transition plan.
- **Identify and develop with the planning team what constitutes a meaningful day for the person so that services or supports to address the person's choices are in place when the person moves to the community.** Often community transitions fail because of poor planning in developing day programming that meets the preferences and needs of the person. This may include planning for educational and vocational opportunities as well.
- **Negotiate with the LME for additional state funding when needed.** Often individuals transitioning to the community have significant support needs that exceed the services offered through the waiver. These support needs may include funding for additional staff for a short period of time, equipment needs, etc.
- **For individuals transitioning from the developmental centers, work with the**

- **developmental center to plan for center staff to accompany the person on their first day in the community.** Also, plan with center staff for ongoing consultation and support for a time limited period.

Note: The Person Centered Plan must be approved by the statewide utilization review vendor as well as the DMH/DD/SAS prior to receiving community services. Case management services may be billed up to 60 days prior to discharge with authorization.

Elements of successful transition planning include:

- Implementation of person centered planning principles and the development of a person centered plan that supports the preferences, needs, services and supports of the individual to insure a quality of life in the community
- Strong individual/guardian involvement
- Open communication and collaboration between the person, guardian, LME, case manager, institutional staff, residential provider, MFP coordinator, and DMH/DD/SAS waiver team staff
- LME willingness to negotiate budget issues
- Provider willingness and flexibility to put in the time and effort to work with the institutional staff in designing the optimum community home setting and programs to best meet the individual's preferences.

Note: All individuals with behavioral challenges transitioning from the developmental centers to the community must be referred to one of the NC-START teams.